HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind

Healthy Indiana Program (HIP) Frequently Asked Questions
For Health Care Providers

Q. How do providers enroll in HIP?

A. Providers must enroll as an Indiana Medicaid (Indiana Health Coverage Programs, IHCP) provider and must be affiliated with one or more of the HIP insurers.

- To enroll with **Indiana Medicaid,** call 1-877-707-5750 or go to www.IndianaMedicaid.com.
- For **MDwise with Americhoice** provider network information call Sherri Miles at 317-829-5532 or Dan Westlake at 317-630-2838.
- For **Anthem Blue Cross Blue Shield** provider network information call Linda Barrabee at 1-317-287-6270.

Q. How are providers reimbursed for services provided to HIP Members?

A. Providers will submit claims for HIP members to the HIP insurers in the manner required by the insurers. The insurers will process the claims and reimburse providers.

Q. What are the payment rates? Will provider reimbursement vary by Insurer?

A. The state law that created HIP requires that HIP services be reimbursed at Medicare reimbursement levels. Plans will reimburse 130% of Medicaid rates when a Medicare rate is not defined.

Q. What about Medicare add-on payments and co-payments required for inpatient hospitalizations?

HIP Insurers are not required to reimburse providers for Medicare add-on payments. Since the HIP plan does not require co-payments for inpatient services, plans will be required to include Medicare deductibles and co-payment amounts in their payments to providers. For example, if Medicare reimburses $2,000 for an inpatient stay, and requires the patient to pay $800, HIP reimbursement to the hospital would be $2,800.

Q. What co-payments will HIP require providers to collect?

A. The only HIP service with a co-payment is emergency room services. Hospitals will collect a co-payment from each HIP member that visits the emergency room. The amount of the co-pay

will be listed on the individual's insurance card. The amount of the co-pay, which varies by family circumstances, will not exceed $25 per ER visit.

If, at the time of the emergency visit, the purpose for the visit is clearly an emergency and the patient is admitted to the hospital as inpatient, the hospital can waive the co-payment.
In the event that a patient is not admitted, and the emergency room visit is determined to have been an actual emergency (as defined by prudent lay-person definition),the HIP insurer will return the co-pay to the member.

Q. What if the person does not have the copay, does the provider still have to provide services?

The person must receive an appropriate medical screening examination under the Emergency Medical Treatment and Active Labor Act (EMTALA). Assuming the individual actually has an available and accessible alternative non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, before providing non-emergency services the hospital may either:

- Require payment of the HIP co-payment before providing the service, or
- Provide the patient with the name and location of an alternate non-emergency service provider that is available and accessible to the patient. Alternate provider treatment will provide the member with cost avoidance of the state-specified higher cost sharing for the inappropriate use of the ER.

Q. Will medical providers require self-pay when a HIP enrolled provider performs a service subject to the individual's POWER account?

A. No. The member's POWER account will be administered by the insurer. Providers will bill the insurer for all services provided to a HIP member. The insurer will debit the member's POWER account as appropriate.

Q. How will providers be reimbursed if a HIP member disenrolls from the Plan? What if the POWER account is not fully funded? In these circumstances will providers need to try to collect from the member?

A. All covered services provided during a HIP eligibility period will be paid by HIP insurers. In some cases, a member will leave HIP owing the insurer for unpaid POWER account payments. It will be the HIP insurer's responsibility to pay the provider and to collect from the member during the active eligibility period.

Q. How can providers check that an individual has active enrollment on the service date?

A. To verify that a patient has coverage, providers should contact the insurer in the manner listed on the member's health plan card. Beginning Jan. 1, 2008, providers may verify HIP eligibility through the State's Eligibility Verification System (EVS) or by contacting the HIP insurer as indicated on the patient's insurance card. EVS will identify enrolled HIP members and will indicate each member's insurer name along with the insurer's telephone number.

Q. HIP will reward members who receive pre-defined preventive services by allowing the individual to carry over to the next year any amount remaining in the member's POWER account. How will HIP determine which preventive services are required for each member?

A. In the first year, HIP will consider all members as having received appropriate preventive services if they had a general physical while covered by HIP. FSSA medical staff will set standards for appropriate preventive services for HIP members to be used in subsequent years. These standards will be based on the age, gender and medical histories of HIP enrollees.

Q. Are family planning services considered preventive care such that member POWER Account contributions will not be required?

A. No, family planning services are not considered preventative care.

Q. How will providers be reimbursed for services provided to a pregnant HIP member during the period before her coverage is changed from HIP to Hoosier Healthwise?

HIP does not cover pregnancy care. In order to obtain coverage through Hoosier Healthwise, a HIP member who becomes pregnant must promptly report her pregnancy to the State. The member must submit to Division of Family Resources (DFR) positive proof of pregnancy that includes member and medical provider contact information along with the Change Report Form. The necessary documentation to initiate enrollment into Hoosier Healthwise may include results of a medical provider's pregnancy test or a letter from a licensed health care provider along with the Change Report Form which is accessible at: http://www.state.in.us/icpr/webfile/formsdiv/44151.pdf .

Providers who see a pregnant HIP member can assist in this process by giving the patient a signed statement of pregnancy and encouraging her to send the statement to the State.

Any claims for maternity services provided to a HIP member will be denied by the HIP Plan. Upon effective coverage through Hoosier Healthwise, claims for covered health care services will be paid. Providers should re-submit claims previously denied by the HIP Plan to Hoosier Healthwise after the woman is enrolled in Hoosier Healthwise.

Q. How will the State determine if HIP applicants qualify for the Enhanced Services Plan?

A. The HIP application asks applicants to indicate whether they currently have or have previously had certain medical conditions. These conditions include cancer, organ transplants, HIV, AIDS, aplastic anemia, frequent blood transfusions, hemophilia or other rare bloodstream diseases. If an applicant answers "yes" to any of these questions they will be enrolled in the Enhanced Services Plan (ESP) which will allow them to receive specialized care and access to specialists best suited for their medical condition. The two HIP insurers, Anthem Blue Cross Blue Shield and MDWise with AmeriChoice may also make referrals to the ESP plan during the first 30 days of an individual's HIP enrollment or at the end of a HIP member's 12-month eligibility period.

The State will verify that those enrolled in ESP qualify for the program by contacting providers that are identified by the member as their treating medical provider. A short questionnaire, along with a medical release statement will be faxed to the provider. The provider should answer the questions in ink and return the completed questionnaire by fax to Milliman. The process will be administered for the State by Milliman and is designed to not be burdensome for providers.

If the provider's response verifies that the patient qualifies for ESP, the individual will remain enrolled with the ESP Plan. If the response indicates that the patient does not qualify for ESP, the patient and his or her POWER account balance will be transferred to the HIP insurer of the patient's choice or auto-assigned if the patient does not indicate a Plan of Choice.

Q. How will a provider know what services are covered under HIP along with the insurer's fee schedule for HIP?

A. HIP insurers will provide this information to providers through a provider manual and provider information on the insurer's website.